fibrosis represents a reversible cause of renal failure, it would be wise to keep this clinical picture in mind.

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Use of Barbiturate Suppositories

TO THE EDITOR: We thought it relevant to present the experience of one of us (L.E.S.) with the use of barbiturate suppositories as an alternative to orally given barbiturates:

In my community it is not an infrequent occurrence that there is a death associated with alcohol use and barbiturates. There is often the query, was this accidental or suicidal? Did the victim succumb from repeated ingestion of an oral barbiturate while intoxicated from alcohol and so not recall the number of pills ingested? The therapeutic to lethal ratio varies in sedative/hypnotic barbiturates, especially when associated with alcohol use. This makes accidental death feasible and intentional suicide easy.

In general, it is difficult to cure alcohol abuse as well as withdraw barbiturates from patients who have been using them chronically for sleep for many years. It is that kind of patient, albeit a common problem in our society, for whom I began prescribing rectal suppositories 15 years ago. Since that time I have witnessed no *accidents* or suicides in my practice. Further, I have extended the limited prescription of rectal suppositories to patients who have been on oral barbiturates but who are emotionally unstable and possibly suicidal. The abuse potential is much lower with rectal suppositories, and with my patients using them instead of oral barbiturates, I sleep better.

The Los Angeles County Coroner has never seen a death from overdose with rectal suppositories, although patients have taken them orally with suicidal intent. The reason is apparently due to poor and delayed gastrointestinal absorption. The use and misuse of sleeping pills cannot be changed overnight. The use of rectal suppositories does not curtail the problem, but it may alter it so that the consumer can live with it more safely.

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Hyperventilation Versus Bicarbonate Therapy for Alkalinization in Tricyclic Antidepressant Overdose

TO THE EDITOR: Hoffman and McElroy's recent article "Bicarbonate Therapy for Dysrhythmia and Hypotension in Tricyclic Antidepressant Overdose"[1] was of great interest.

It is well recognized that alkalinization, either by bicarbonate or hyperventilation, can dramatically reverse the manifestations of tricyclic antidepressant overdose (TCA) toxicity. There remains some controversy, however, as to whether bicarbonate or hyperventilation is the preferable method of achieving this.

Kingston[2] recently described treatment with hyperventilation in similar cases, and felt that hyperventilation may have some advantages over bicarbonate. Hyperventilation may be immediately effective compared with the potential delay of bicarbonate infusion. The alkalemia induced by bicarbonate changes only the extracellular pH, because cell membranes are poorly permeable to hydrogen and bicarbonate compared with carbon dioxide. The rise in extracellular pH may decrease ventilation, diminishing the rise in pH; and may actually paradoxically decrease intracellular pH. In addition, the hazard of sodium overload may predispose to pulmonary edema. And, last, metabolic alkalosis induced by bicarbonate makes it more difficult to wean patients from mechanical ventilation, a common problem in intensive care units. Overall, I think the evidence favors hyperventilation as the method of choice.

I would also like to comment on antiarrhythmic drug use during TCA overdose.

Lidocaine has its proponents[3] and detractors.